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# Nonparaphilic Sexual Addiction

by

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Impulse control disorders of a sexual nature have probably plagued humankind from its beginnings. Sometimes classified today as "sexual addiction" or "nonparaphilic sexual addiction,"<sup>1</sup> it has been labeled by at least one professional working within the field as "The World's Oldest/Newest Perplexity."<sup>2</sup> Newest, because for the most part, the only available data until recently has come from those working within the criminal justice system and as Patrick Carnes points out, "they never see the many addicts who have not been arrested."<sup>3</sup> By definition, both paraphilic<sup>4</sup> and nonparaphilic sexual disorders "involve intense sexual urges and fantasies" and which the "individual repeatedly acts on these urges or is highly distressed by them . . ."<sup>5</sup> Such disorders were at one time categorized under the classification of neurotic obsessions and compulsions, and thus were usually labeled as disorders of an obsessive compulsive nature. Since those falling into this latter category, however, perceive such obsessions and compulsions as "an unwanted invasion of consciousness"<sup>6</sup> (in contrast to sexual impulse control disorders, which are "inherently pleasurable and consciously desired"<sup>7</sup>) they are now placed under the "impulse control disorder" category.<sup>8</sup>

To help clarify the distinction:

The purpose of the compulsions is to reduce anxiety, which often stems from unwanted but intrusive thoughts. Although obsessions and compulsive behavior may help control deeper anxieties that the individual dares not face consciously, the ultimate effect can be highly maladaptive. Not only do obsessions and compulsions perpetuate discomfort for the victim but they also have negative effects on interpersonal relationships.<sup>9</sup>

Disorders of sexual impulse control, on the other hand, would include these essential features:

1. Failure to resist an impulse, drive, or temptation to perform some act that is harmful to the person or others. There may or may not be conscious resistance to the impulse. The act may or may not be premeditated or planned.
2. An increasing sense of tension or arousal before committing the act.
3. An experience of either pleasure, gratification, or release at the time of

committing the act. The act is ego-syntonic in that it is consonant with the immediate conscious wish of the individual. Immediately following the act there may or may not be genuine regret, self reproach, or guilt.<sup>10</sup>

Regardless of how such a disorder is classified, however, the fact remains that sexual addiction would seem to be a serious problem in our western society today.<sup>11</sup> Yet some today would still question whether such a disorder actually exists. Like the history of alcoholism, many, at least until recently, have suggested that sexual addiction is not really an illness. "If such an illness did exist, the numbers were very small and had little significant impact . . . Besides, it was thought there was no effective way of treating these people since they were considered basically incorrigible . . ." <sup>12</sup> Today, the achievements which enable research in the field of sexual addiction to be carried out is largely the result of the groundwork laid by those who had earlier studied both alcoholism and eating disorders: the former, by its discovery of an illness which has one of its essential features that of being "out of control,"<sup>13</sup> and the latter, by its finding that an addiction can actually embed itself within "a natural physiological function."<sup>14</sup>

According to Patrick Carnes, a leading figure and recognized expert in the field of sexual addiction, there are a number of stages which make up what he refers to as the "addiction cycle" of the sexual addict. Carnes describes these stages as follows:

1. Preoccupation - the trance or mood wherein the addicts' minds are completely engrossed with thoughts of sex. This mental state creates an obsessive search for sexual stimulation.
2. Ritualization - the addicts' own special routines which lead up to the sexual behavior. The ritual intensifies the preoccupation, adding arousal and excitement.
3. Compulsive sexual behavior - the actual sexual act, which is the end goal of the preoccupation and ritualization. Sexual addicts are unable to control or stop this behavior.
4. Despair - the feeling of utter hopelessness addicts have about their behavior and their powerlessness.<sup>15</sup>

The pain, says Carnes, which addicts inevitably experience while trapped in this cycle can be easily relieved or numbed by re-engaging in the sexual preoccupation, which, in turn, becomes the reinforcing mechanism which keeps the addict locked within the addiction cycle. Thus, do sexual addicts become the "hostages of their own preoccupation. Every passerby, every relationship, and every introduction to someone passes through the sexually obsessive filter."<sup>16</sup>

Carnes sees the goal of the sexual addict as the attempt to capture the "high" or "intoxication" of the human emotional experience "generated by courtship and passion."<sup>17</sup> In this sense, the addict is not much different from those dealing with other kinds of obsessive/compulsive addictions.<sup>18</sup> This "high" is enhanced for the addict by his/her ritualization, which precedes the actual behaviour.

Professionals have often wondered why sex offenders use the same 'MO' (modus operandi or method) each time, when it only makes apprehension easier. The answer is



simple. A ritual helps the trance. Like a yogi in meditation, the addict does not have to stop and think or disrupt his focus. The ritual itself, like preoccupation, can start the rush of excitement.<sup>19</sup>

According to Carnes, this ritualizing often takes on an importance extending even beyond the goal itself - sexual orgasm - because of the role it plays in intensifying the excitement.<sup>20</sup>

Once the addict has "acted out" (the cycle's third phase), s/he eventually comes to the phase of despair. Suddenly, the addict is faced with the reality that s/he has failed once again to live up to his/her expectations, that s/he has again engaged in behaviour which may have been "particularly degrading, humiliating, or risky."<sup>21</sup> This despair, and the pain which consequently accompanies it, serves as the "trigger" for re-entering the addictive cycle by a return to sexual preoccupation.<sup>22</sup>

Carnes spends a fair amount of space examining models of sexual addiction which he himself finds inadequate. The first involves viewing the addiction "as a moral choice."<sup>23</sup> In this view, a person's failure to control sexual impulses would be seen basically as a result of weak moral character.<sup>24</sup> According to Carnes, however, this is the same problem which led professionals to view alcoholism as a moral problem rather than a disease:

The alcoholic believed he was totally responsible for his drinking; society and his family certainly held him accountable. However, the pain caused by repeated failures to control his drinking through will power in effect intensified the problem. Family members operating under the same assumptions would also try to control the alcoholic's drinking, which added destructive energy to the alcoholic's self-defeating cycles.<sup>25</sup>

Fortunately, the paradigm shift which led specialists to label alcoholism "as an illness with a definite symptomology"<sup>26</sup> has taken the problem out of the moral realm and placed it within that of the medical. In addition, groups such as Alcoholics Anonymous (A.A.) strongly emphasize the need for alcoholics to acknowledge their own powerlessness in the face of their addiction.<sup>27</sup> By doing so, the person "regains choice" and as such, is empowered to reclaim values important to him/her "by moving out of the realm of morality."<sup>28</sup>

Carnes sees the need to view sexual addiction in a similar fashion. For example, studies have shown that a large percentage of those struggling with sexual compulsions were sexually abused themselves as children. Others have revealed a family history of sexual improprieties which, like alcoholism, are multigenerational in character. "Abuse," says Carnes, "is simply one indicator that children who were powerless over what was done to them can become powerless over their own behavior in later years."<sup>29</sup>

The "biological model," which Carnes likewise rejects, is basically that God made a "mistake" when creating some people by putting "too much sex . . . in their genes."<sup>30</sup> One hypothesis of particular interest to Carnes is that "some people are naturally addiction-prone to pleasure."<sup>31</sup> Carnes quotes from Richard Solomon's "opponent process" theory of addiction" which "suggests that psychological and physiological responses of pain and pleasure have a common pattern which in the right sequence can turn anyone into a pleasure 'junkie.'"<sup>32</sup> Carnes thinks this view holds potential, but at the present time, offers no definitive answers. In short, as far

as the biological model is concerned, there is no conclusive evidence to support any "consistent relationship between sexual compulsivity and biological factors,"<sup>33</sup> says Carnes.

The situation is similar with both the behavioural model and the psychodynamic or personality model: there is no conclusive evidence at the present time on the origins of sexual compulsivity. Part of the problem, of course, is the question of what constitutes "normal" from "abnormal" sexual behaviour. Culture, naturally, plays a large role in the decision, says Carnes. What might be considered acceptable in one culture may not be considered so in another. The changes in attitudes about sexual behaviour which have taken place in western society over the last 30 years have been nothing short of revolutionary. This has been a major factor in our reluctance "to name the addiction for what it is," claims Carnes, and "testifies to the enormous significance we attribute to sex in our culture."<sup>34</sup> Add to this the problems of professional bias and prejudice among professionals in the treatment fields, as well as the inability to recognize compulsive sexual behaviour, and the process of diagnosing sexual addiction becomes even more difficult.

In light of the shortcomings of these findings, Carnes believes it is time to develop guidelines for a new model, a model which clearly establishes firm criteria for the diagnosis of sexual addiction. Carnes begins this work by adopting three problem areas previously identified by Orford as obstacles to developing such a model and uses them to establish firm guidelines for his own fledgling model: "(1) it is difficult to separate normal and abnormal sexual behaviour; (2) it is difficult to determine when loss of control occurs; and (3) it is difficult to assess the role of culture in this addiction."<sup>35</sup> The guidelines which Carnes comes up with for his own model are the following:

A) "A model of sexual addiction must account for the wide range of sexual behaviour."

B) "A model of sexual addiction must see 'loss of control' on a continuum as opposed to a yes/no dichotomy."

C) "A model of sexual addiction must factor in the role of culture as part of the illness."

D) "A model of addiction must indicate a definition of positive principles of change useful to the therapist and understandable to the client and concerned family members."

E) "A model of sexual addiction must specify the relationship between the internal system which drives the addict and the exterior interdependent support systems which give the addiction its life and power."<sup>36</sup>

Carnes admits that in its earliest stages, "sexual behaviour that is a precursor to addiction is difficult, if not impossible, to distinguish from normal sexual behaviour."<sup>37</sup> There are at least some early signs, however, which, studies suggest, may eventually lead to sexually-compulsive behaviour. One is that the early sexual activities of such addicts are normally described by them as "exceptionally intense. Sex seemed to be more important to them than to their peers."<sup>38</sup> A second is that "self-stimulation was not merely experimentation; it was already a way to



anesthetize emotional pain.”<sup>39</sup> A third is the shame experienced as a result of their sexual experimentation, which led them to question whether or not they were “normal.” And a fourth is that sex for them came to be used as a means to get through a variety of difficulties in life. Once habitualized, such experiences were forged by the addict “into a ritualized pattern for coping with life.”<sup>40</sup>

In the exceptional cases, such indicators do not apply. Instead, for some addicts

their growing up was quite normal. No sexual abuse. Relatively normal family lives. No unusual sexual problems. Even very limited sexual experience. But given an extraordinary situation with great stress and intensely pleasurable sexual experience pursued to excess, they will begin to form a potent pattern of sex as stress relief with lifelong consequences.<sup>41</sup>

Carnes believes there are “catalysts” in the addict’s life which bring on the addiction: such catalysts will usually take the form of either environmental situations, such as one which combines “high performance expectations with a low degree of structure,”<sup>42</sup> or catalytic events, such as experiences of abandonment or sexual experiences in one’s early years. In either case, once a “pattern of behaviour is developed, the addict enters the establishment phase of the sexual addiction,”<sup>43</sup> wherein the “regularity” of the addiction cycle (preoccupation, ritualization, sexual compulsivity, despair) becomes easily discernable.

Although some addicts - those “whose behaviour stays more or less consistently at the base line of established addiction”<sup>44</sup> - would seem to remain at this “establishment phase,” others move on to one of four progressive developmental stages which Carnes labels contingent phase: escalation mode; contingent phase: de-escalation mode; acute phase; and chronic phase. In the last of these, the chronic phase, the addiction has become irreversible, and as a result, is no longer responsive to treatment.<sup>45</sup>

In assessing the illness of sexual addiction, Carnes focuses on five primary aspects of the disease. The first is that the addiction is multivariate, rather than singular in origin. By this Carnes means that no single cause can be determined. Instead, “a constellation of factors emerges: catalytic events and environments; childhood experiences of extreme family dynamics; co-addictive systems which feed compulsive behaviour.”<sup>46</sup> The second is that the addiction is contingent, rather than progressive. It is this particular quality of the illness which Carnes claims can make the addiction so elusive. “The fact that it can be controlled, even for years, makes it hard to see any pattern which suggests that the individual has a problem controlling his or her sexuality.”<sup>47</sup> The third, that addiction is eurytopic (meaning it is a system which “can survive in many environments”) rather than stenotopic, or “limited in its range.”<sup>48</sup> In short, Carnes believes that “sexual addiction can flourish in a rigid or a chaotic family environment, in a sexually permissive culture or sexually restrictive culture.”<sup>49</sup> The fourth is that “the addiction is extensive in range, level, and intensity,”<sup>50</sup> and the fifth, that the addiction is both autonomous and multisystem. By this Carnes means that not only can the disease “perpetuate itself no matter what its environment” but also that the addictive system is “interconnected with six other systems: the biological system, relationship networks, the family system, the work system, concurrent addictions/mental illness, and environmental systems.”<sup>51</sup> Each of these six systems

can be used to help identify whether sexual addiction is an interconnected problem to be examined. For example, physicians and health professionals will often be the first to encounter symptoms of the addiction which are biological in nature, such as genital infections, venereal diseases, abnormal muscle tissue, and signs of physical abuse. Relationship networks, the family system and the work system may all reveal a peculiar isolation in relation to others. Concurrent addictions/mental illness may underline how some addictions work in a "mutually supportive fashion."<sup>52</sup> Environmental systems explain the effects a person's surroundings have on their sexual compulsivity.<sup>53</sup>

One of the primary goals of treatment, according to Carnes, is that of helping the addict "reclaim a healthy and vibrant sexuality."<sup>54</sup> This is accomplished, not simply by some form of sexual abstinence but by working "to bring about a profound shift of beliefs and behaviour in which the obsession loses its power."<sup>55</sup> While twelve-step treatment groups for alcohol and drug addiction rightly emphasize abstinence, Carnes believes that food and sex, because of their psychobiological components, make them more difficult to treat. Nevertheless, Carnes views twelve-step groups as an important and integral part of the treatment and recovery process, and sees them as most effective when working in unison with trained professionals.

Intervening treatment begins, says Carnes, by an affirmation of the addict's worth as a person. The purpose of such affirmation is to penetrate "the primitive logic of core beliefs, opening the addict to new possibilities."<sup>56</sup> The professional also speaks of the addiction as an illness, which has the effect of decreasing the shame of having lost control.<sup>57</sup> In addition, the awareness of other addicts suffering similar difficulties helps remove feelings of isolation.

Sometimes, the addict's belief system and thinking is impaired to the degree that s/he refuses to acknowledge the problem, despite clear evidence to the contrary. In such cases, "the therapist must confront the gross defenses and work toward acceptance of the 'illness.'"<sup>58</sup> Another aspect of the treatment process must concentrate on the development of "feedback mechanisms that keep reality in focus," with the therapist or twelve-step group serving as a "standard reality test"<sup>59</sup> for the addict. This is necessary, says Carnes, for a number of reasons, one being that addicts tend to either not perceive reality, distort reality, or even to ignore or deny reality. For example,

Many addicts in treatment report a loss of memory or a loss of contact with here and now events due to a combination of factors including obsessions, overextension, exhaustion, or anxiety. Addicts in rapid escalation phases or acute phases of the addiction often display symptoms of not having been present when something significant was going on.<sup>60</sup>

This process can be countered by ongoing feedback, during which the addict is challenged to recognize defenses and set them aside, to share openly with the therapist and with his/her twelve-step group so that secrets are not nurtured, and to have any delusional and/or impaired thinking confronted openly, yet fraternally.

Another important area of work in treatment is helping the addict replace his/her obsessive preoccupations with sex by developing new strategies in order to



cope with anxiety. One way this may be accomplished is by the "awareness of personal limits."<sup>61</sup> The addict seeks ultimate fulfillment through his/her obsessing; acknowledgement that such an ideal is not attainable brings the addict back to the world of reality.

Likewise, with ritualization. In fact, Carnes suggests that it may sometimes be necessary for a therapist to place prohibitions on the addict's rituals. Carnes admits that while some therapists "may experience discomfort about taking responsibility for client behavior," they should keep in mind that "by definition this illness renders its victims powerless."<sup>62</sup> Since preventative measures are often necessary to stop ritualization, it is important for both therapist and addict to understand how rituals support the addiction cycle.

One technique for ritual identification is guided imagery. The therapist asks the addict to relax and to share a series of fantasies about the addictive behavior. Whatever is used as part of the ritualization of the story line - clothing, dressing, undressing, cross-dressing, bathing, cars, bars, hotels, specific cities, conferences, work situations, drug use, animals, films, music, magazines, pornography - is catalogued as a potential ritual cue for the addiction.<sup>63</sup>

Another asks the client to list all high-risk situations where the sexual acting-out is most likely to occur, and then to identify the common elements. Once identified, the therapist works with the client with the intent of creating "life-enhancing rituals to replace destructive addictive rituals."<sup>64</sup>

Carnes sees involvement in the twelve-step program as the surest path to maintaining a healthy set of rituals once they are acquired, since therapy will eventually terminate, but the new set of rituals must continuously be put into practice in order to avoid the possibility of relapse. According to Carnes, a sure sign that the addict is making progress along the road to recovery is when s/he begins to perceive "the ongoing rituals as a symbol of new life."<sup>65</sup>

Although complete sexual abstinence may not be a set goal for the addict, nevertheless, therapists

need to set specific limits on the sexual behavior . . . A working definition of abstinence needs to be in place while he or she will determine what sobriety means. For example, if the client has six ongoing "serious" sexual relationships, the therapist might recommend that all sexual behavior with these partners cease until the client can sort out his/her feelings. At the least, the casual partners need to be dropped and some decisions made about what can be salvaged from the other relationships. Often the clearest path to recovery is simply to suspend all sexual relationships. But if a committed relationship is involved, then that partner needs to be informed and also involved in therapy because sooner or later he or she must deal with the illness.<sup>66</sup>

Carnes himself would seem to favor what he calls the "celibacy contract," where a therapist "asks the client to commit to a period of celibacy, usually twelve weeks long."<sup>67</sup> Carnes compares this to the practice of fasting which, he believes, can have "a cleansing experience."<sup>68</sup>

For the sex addict, celibacy has specific benefits. First, the contract makes explicit the power of the destructive addictive pattern. For someone who has used sex to avoid suffering for most of a lifetime, life without it is terrifying. Addicts learn, however, that



they can survive without sex and with the help of others . . .

. . . Celibacy (including no sex with spouse and no masturbation) means that addicts are no longer able to use sex to deal with difficult feelings. They are then fully open to the therapeutic process because the pain is not deadened and the addict has to rely on new methods to survive . . .<sup>69</sup>

Other benefits of the celibacy contract, says Carnes, include a facilitated access to blocked memories,<sup>70</sup> new insights (which in turn, affect internal beliefs and impaired thinking), and, in general, a better understanding of his/her illness. This period of abstinence can also be the occasion for intense spiritual growth which gives new meaning to present relationships.<sup>71</sup> The practice of celibacy, however, "should not be like a diet which only becomes a period of deprivation and which achieves no significant change in the obsession."<sup>72</sup> Rather, as "in eating disorders, the task for the client is to learn how to eat differently. As opposed to using sex as a solution or as medicine, sex becomes a way to celebrate relationship and life."<sup>73</sup>

One of the real dangers which exist is that the client may become so overwhelmed by the shame of past behavior that, combined with a sense of vulnerability and hopelessness about the future, s/he may see suicide as the only option. Again, the care and support of a twelve-step group can be of enormous help during such difficult periods in recovery.<sup>74</sup>

Finally, the therapist needs to assist the client in developing a relapse prevention plan. This is initiated by first discussing with the addict the consequences of a relapse. To aid the client's understanding of such repercussions, s/he may be asked to write out on a piece of paper both the positive aspects of recovery as well as the negative ones. This is followed by a review of the addict's very own, unique addictive cycle, placing special emphasis on "specific stressors" likely to cause difficulties;" "high risk environments;" "entitlement scenarios," leading the addict to feel "entitled" or deserving to act out; what has been successful in the past, and what has not; predictable cycles/seasons; delusional thinking which encourages acting out.<sup>75</sup> The prevention plan itself focuses on three concerns: action for preventing a relapse, what to do during a relapse, and how to respond once relapse has occurred. Preventing a relapse, for example, involves "anticipating all the slip-inducing possibilities and rehearsing for them."<sup>76</sup> Of most importance in regards to the prevention plan is that it "nurture the addicts. Rewards need to be built in; the goal is to avoid feeling deprived."<sup>77</sup>

In summary, then, we have seen the difficulty professionals have had, not only in classifying what behavior does or does not constitute a nonparaphilic sexual disorder, but even whether nonparaphilic sexual disorders can actually fit into one or another of a number of possible categories. We have examined the theories of Dr. Patrick Carnes, a leading pioneer in the assessing and treating of sexual addictions, and have accepted, in principle, his description of the four stages of the "addiction cycle." We have also looked at a number of models in which to explain sexual addiction, all of which were rejected by Carnes in favor of his own model. Assessing sexual addiction was shown to be equally difficult by Carnes, primarily because of the various conditions under which the illness can survive. Finally, treatment which has been shown to be most successful would seem to involve both a number of therapeutic techniques as well as full-fledged involvement with a

twelve-step support group.

I have chosen to use Carnes as the main authoritative source for this paper, not only because of his pioneering work and world-renowned reputation in this particular field but also because much of the more recent research seems to support his theories. One need only scan the reference section of a number of the journal articles examined in this study to find his writings being cited, especially when attempts are made to define and categorize behaviors which fit the classification of nonparaphilic sexual addiction. For example, Sprenkle ("Treating a Sex Addict Through Marital Sex Therapy") relies heavily upon Carnes and incorporates a number of his theories which, in turn, take on a central role in the validation of his own work. A quick perusal of Schwartz's and Brasted's ("Sexual Addiction") reveals a strong emphasis on and virtual duplication of Carne's writings.

Having said all this, there remains but one question in this writer's mind which needs to be asked. The question revolves around the problem of human freedom and whether the last trace of this freedom is ever surrendered when addiction takes hold. It would seem fair to say that an element of freedom always remains, for merely to acknowledge one's own powerlessness involves a choice.

... the will is always able to take a stand even if the situation is physically or psychologically unchangeable for the moment. This is also true on the boundary situations of sin and neurosis. When I am the victim of a habitual sin or of a neurosis, then my freedom and responsibility are diminished. However, I should not underestimate the responsibility which remains to me in spite of the fact that I cannot at once escape my neurotic or sinful reactions ...

... It is necessary for me to maintain some areas of freedom of thought and activity, however insignificant and seemingly ineffective, against the onslaught of passion, habit, and neurosis. I must hold on to this last possibility of 'not totally consenting interiorly' to that which seems to draw me in without the possibility of resistance. This preservation of a conviction of freedom, even if it does not help me to transcend totally the symptoms of neurosis and sin, will at least preserve my awareness of a last vestige of that human dignity which extends as far as freedom does. Without this awareness, everything seems lost. It is in this last outpost and refuge on my disturbed existence that grace may move me to turn to God in a dialogue between humble contrition and infinite mercy.<sup>78</sup>

Though powerless, the addict, it would seem, is still free, however limited this freedom might be. Despite the odds, s/he can still choose, can still make a choice to abandon him/herself once more to the vicious cycle of addiction - with all which that entails - or seek to be truly free, once and for all, of the chains which have held him/her bound.

## References

1. Patrick Carnes defines sexual addiction as "a 'pathological relationship' with a mood-altering experience ... Sex addicts have lost control over their ability to say no; they have lost control over their ability to choose. Their sexual behavior is part of a cycle of thinking, feeling, and acting which they cannot control." (Patrick Carnes, *Contrary To Love*, Minneapolis, MN, 1989, pp. 4-5) Schwartz and Brasted call it "a syndrome in which a person is excessively preoccupied with sex; sexual thoughts persistently intrude and distract, and some individuals become involved in repetitive compulsive sexual activity that becomes undesirable." (Mark F. Schwartz, ScD. and William S. Brasted, Ph.d., "Sexual Addiction," *Medical Aspects of Human Sexuality*, Vol. 19 (10), Oct. /85, p. 103).



Kafka includes under the description of nonparaphilic sexual addiction "culturally acceptable sexual interests and behaviors which increase in frequency or intensity so as to significantly interfere with the desired capacity for a sustained intimate sexual relationship." (Martin P. Kafka, M.D., "Successful Antidepressant Treatment of Nonparaphilic Sexual Addiction and Paraphilias in Men," *Journal of Clinical Psychiatry*, Vol. 52 (2), Feb./91, p. 60).

2. Carnes, *Contrary To Love*, p. 22.

3. Ibid. "I believe that we are currently at the same stage of understanding sexual addiction as we were when we believed that the typical alcoholic is a street drunk. We know now that the housewife who drinks alone is in as much need of strong recovery as the street drunk or the acting-out alcoholic. The sexual anorexic is as desperate inside as the rapist or the child molester. Her behavior may not be as dangerous to society . . . it is dangerous to her . . ." (Ann Wilson Schaefer, *Escape From Intimacy*, San Francisco, CA, 1989, p. 26).

4. DSM-III-R applies the name "paraphilias" to the following list of sexual disorders: "pedophilia, exhibitionism, voyeurism, sexual sadism, sexual masochism, fetishism, transvestism, zoophilia, and frotteurism." (Frank Costin and Juris G. Draguns, *Abnormal Psychology: Patterns, Issues, Interventions*, Toronto, ON, 1989, p. 218).

5. Ibid. According to Kafka, a number of researchers "have noted a continuity between paraphilias and nonparaphilic sexual addictions." (Martin P. Kafka, M.D., "Successful Antidepressant Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men," p. 60).

6. Costin and Draguns, *Abnormal Psychology*, p. 358.

7. Ibid.

8. "Paraphilic behaviors are currently characterized as impulse control disorders. Nonparaphilic sexual behaviors, however, are considered 'addictions' in current nosology. This distinction could imply a difference in their respective etiology as well as treatment. Paraphilias and nonparaphilic sexual addictions collectively have also been described as addictions, obsessive compulsive spectrum disorders or affective spectrum disorders." (Martin P. Kafka, M.D. and Robert Prentky, Ph.D., "Flouxetine Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men," *Journal of Clinical Psychiatry*, Vol. 53 (10), Oct./92, p. 351). Kafka notes the difficulty involved in attaining unanimity among researchers for this particular classification; he admits to ongoing "controversy as to whether the form of these behaviors constitutes an addiction, a compulsion, forms of hypersexuality, or a disorder of impulse control." (Kafka, "Successful Antidepressant Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men," p. 60). For example, according to Stein et al., the obsessions and compulsions of obsessive-compulsive disorder (OCD) patients may at first "appear markedly different from the symptoms of patients with paraphilias and sexual addictions. Thus, patients with OCD typically experience their symptoms as intrusive or senseless. On the other hand patients with paraphilias and sexual addictions typically experience their sexual urges and acts as pleasurable. Whereas OCD patients may experience relief after completion of rituals, patients with paraphilias and sexual addictions may experience guilt or shame on completion of their behaviors. "Nevertheless, paraphilias and related disorders may lie on the obsessive compulsive spectrum. OCD patients frequently have obsessions with a sexual content and may be plagued by religious and moral concerns about sexual issues. Patients with paraphilias and sexual addictions, on the other hand, may have comorbid OCD. Furthermore, OCD patients do not always experience their symptoms as senseless and may obtain a sense of relief from completion of rituals. Conversely, patients with paraphilias and sexual addictions may experience their sexual urges as alien to their self-image, and while enactment of fantasies may be anxiety-relieving, it may also lead to discomfort." (Dan J. Stein, M.B., Eric Hollander, M.D., Donna T. Anthony, M.D., Ph.D., Franklin R. Schneier, M.D., Brian A. Fallon, M.D., Michael R. Liebowitz, M.D., and Donald F. Klein, M.D., "Serotonergic Medications for Sexual Obsessions, Sexual Addictions, and Paraphilias," *Journal of Clinical Psychiatry*, Vol. 53 (8), Aug./92, pp. 267-8). For a discussion on the practicality of the use of the term "addiction" to denote sexually obsessive-compulsive behaviour, see Sally Satel, "The diagnostic limits of 'addiction'," *Journal of Clinical Psychiatry*, Vol. 54 (6), June/93, p. 237 and Dan J. Stein and Eric Hollander, "The diagnostic limits of 'addiction': reply," *Journal of Clinical Psychiatry*, Vol. 54 (6), June/93, pp. 237-8.

9. Costin and Draguns, *Abnormal Psychology*, p. 14.

10. American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 3rd



ed., rev., (DSM-III-R) Washington, D.C., 1987, "Impulse Control Disorders Not Elsewhere Classified," p. 321. DSM-III-R also makes allowance for this particular disorder under the category of "Sexual Disorder Not Otherwise Specified," wherein it lists as such an example "distress about a pattern of repeated sexual conquests or other forms of nonparaphilic sexual addiction, involving a succession of people who exist only as things to be used." (p. 296) Compare Kafka and Prentky, "Fluoxetine Treatment of Nonparaphilic Sexual Addictions and Paraphilics in Men," p. 351: "... nonparaphilic sexual addictions (NPSAs) have not been rigorously operationalized and have been relegated as Sexual Disorders Not Otherwise Specified (NOS)" in DSM-III-R.

11. "Sexual addiction is a progressive disease and ... results in destruction and early death for addicts and often those with whom they are involved. Sexual addiction is of epidemic proportions in this society and is integrated into the addictiveness of the society as a whole ..." (Schaeff, *Escape From Intimacy*, p. 10)

12. Carnes, *Contrary To Love*, p. 14.

13. Ibid.

14. Ibid. "When left unchecked, the adaptive response that led to compulsivity and addiction becomes embedded in the system. Many times adaptive responses are necessary for survival, for example, in the case of childhood sexual abuse. However, when the adaptive response develops into part of an established addiction, only a substantial environmental shift can help stop the self-destructive behavior. Most often, this change in environment is treatment. An intervening system of which the therapist is part helps the damaged system establish a new set of responses and behaviors which brings balance - not another extreme." (Ibid., p. 229)

15. Patrick Carnes, *Out of the Shadows: Understanding Sexual Addiction*, 2nd Ed., Minneapolis, MN, 1992, p.9. Jim Orford, in an article on hypersexuality, sees the common element in all forms of compulsive sexuality as that of uncontrollable desire: "Preoccupation with the object of these desires and with the means of consuming or partaking of it is another recurrent theme. The behavior itself is felt inappropriate and in excess of what the individual or other people or both would consider normal. The activity is often engaged in response to the experience of unpleasant affect. Most significantly is described the experience of conflict and the attendant ambivalence and guilt. Attempts at self-control, through a variety of tactics, are usually described as well." (Carnes, *Contrary To Love*, p. 29) Note the similarities between Carne's stages of the addiction cycle and that of Gorski's which he applies to the alcoholic and drug addict: 1. euphoric recall; 2. positive expectance; 3. a trigger event; 4. obsession; 5. compulsion; and 6. craving. "If the compulsion is strong and persists for a long time, our brain chemistry can change and a craving can be triggered. Craving is a body or tissue hunger for alcohol or drugs." (Terence T. Gorski, *Passages Through Recovery*, San Francisco, 1989, pp. 39; 42). Gerald May argues that a similar neurological event occurs in all addictive processes: "As a first step toward appreciating how the brain functions in addiction, we need to review the importance of balance and equilibrium in brain activity ... All brain functioning, like the rest of bodily activity, depends upon delicate shifts of balance among chemical, cells, and systems of cells. Like human beings, nerve cells can never act in complete isolation from one another. Their interconnections are so extensive that anything happening anywhere within the nervous system is bound to have effects elsewhere. A change in one cell shifts the balance of its local group and of all its functional systems. These changes, in turn, affect the larger systems of the brain, and these then cause changes in other systems of the body ... Adaptions occur through physical changes in the cells of the nervous system: synapses formed and dissolved, connections established and broken, neurotransmitters changed in kind and amount, neuroreceptors altered in number and responsiveness. Adapting to change, then, means going through the stress of withdrawal from the old normality and finding relief when a new normality is established. At this most basic level of human functioning, attachment has made its appearance. I am attached to whatever makes things normal for me. I don't let normality change without a struggle." (Gerald May, *Addiction and Grace*, San Francisco, 1988, pp. 72; 78) For a more elaborate and detailed explanation of this neurological process of addiction, see pp. 72-90.

16. Carnes, *Out of The Shadows*, p. 9. "... sexual addiction is an obsession and preoccupation with sex, in which everything is defined sexually or by its sexuality and all perceptions and relationships are sexualized ... In all its forms, sexual addiction is destructive to the self, to others, and to relationships. Sexual addiction is a source of pain, confusion, and fear for the addict and also for those with whom the addict attempts to relate." (Schaeff, *Escape From Intimacy*, p. 11) "Sexual



addicts escape from their daily troubles by withdrawing into a secret world of fantasy or by having a sexual 'fix.' Frequently, they feel compelled to have sexual releases over and over in a short period, each time feeling different from and alienated from other people, and guilty or shameful. Their sexual preoccupation usually interferes with their relationships and often affects their careers and friendships, to the extent that some sexual addicts risk being arrested or attempt suicide. Each time they act out their sexual addiction, they vow to quit, but like addicts of other activities, they are unable to stop." (Schwartz and Brasted, "Sexual Addiction," p. 103)

17. Carnes, *Out of The Shadows*, p. 10. "The obsession with the intoxication of new love moves into the intoxication of the thrill . . . their addiction is fully as mind altering as any drug or chemical." (Schaefer, *Escape From Intimacy*, p. 66)

18. Compare with the following statements by Craig Nakken (*The Addictive Personality*, New York, 1988): "... no matter what the addiction is, every addict engages in a relationship with an object or event in order to produce a desired mood change." (p. 4) "For the addict, acting out is a way to create certain feelings that cause an emotional and mental shift within the person. It is this shift that the addict desires. By acting out either through thoughts or actual behavior, the addict learns to create feelings of being relaxed, excited, or in control. . . ." (p. 6) "Addiction and the mood change created by acting out is a very seductive process. The addict is seduced emotionally into believing that one can be nurtured by objects or events." (p. 7) Nakken believes it is the consistency and predictability of the mood change which leads to a sense of trust: "Addicts rely upon a mood change and the mood change comes through for them. People, on the other hand, may not always come through." (p. 12) Thus, for those raised in abusive or dysfunctional environments and have learned that people cannot always be trusted, the "trustworthiness" of the mood change can seem all the more desirable.

19. Carnes, *Out of The Shadows*, pp. 10-11. Typical examples include "the attorney who is married, has a family, and spends his lunch hour in a pornographic bookstore placing his penis through a hole to be anonymously fellated; or the man who cruises local department store bathrooms in search of sexual excitement. The illicit activity produces 'hits of adrenalin,' and the risk of apprehension seems to satisfy a need to be caught and punished, or to sabotage successes. . . ." (Schwartz and Brasted, "Sexual Addiction," p. 103).

20. "For the sexual addict, conventional lovemaking becomes undesirable. Closeness, vulnerability, and touching or courting an attractive partner no longer produce sufficient sexual arousal. . . ." The problem "is primarily a disorder of intimacy in which the individual has difficulty consistently in combining sexuality and closeness with a desired partner. The addictive thoughts or behavior become a destructive means of coping with stress. When conflict or problems occur with loved ones or at work, the addict copes by sexual acting-out, thereby never solving the problems or changing the ineffective coping strategies." (Ibid., p. 106).

21. Carnes, *Out of The Shadows*, p. 12.

22. "Following his intense sexual pleasure after acting out, he has a brief escape from the loneliness, boredom, or rage. The escape, however, is short-lived and, consequently, the cycle continually repeats itself." (Schwartz and Brasted, "Sexual Addiction," p. 106).

23. Carnes, *Contrary To Love*, p. 23.

24. "In order to appreciate fully the importance of bad habits, we must consider their physical as well as their spiritual aspects. The facility of acquired modes of behavior is explained by the empirical fact that stimulatory processes connected with each activity will occur more readily the more often the process is repeated. Metaphorically speaking, the mechanism of reflexes becomes smoother. The psychic contents habitually connected with each other become more firmly knit through habit into a stronger psychic association. This psychic association will be stronger still if certain cravings are connected with corresponding phantasies that serve those cravings and furnish a hitherto unconscious tendency with a definite object. This linking of cravings (instincts) with imagination turns impulses into desires (eg., concupiscence). If such desires are not kept under control the connection between the impulse and its object grows stronger and stronger. The satisfaction of the desire yields pleasure. In turn this pleasure stimulates the desire anew. Its appeal will be the stronger the more intimately desire and the desired object have been connected. If a person has repeatedly indulged in his desires, each new temptation will be accompanied by the recollection of similar, equally sinful acts that have yielded satisfaction in the past. Thus, the inclination to evil will be strengthened. At first, such offenses will be accompanied by countermotives like repentance and the



sting of conscience. But as the habit strengthens, these correctives will weaken. Habit encourages the soul, the conscience becomes dull and ineffective, and all countermeasures fail. In order to break such habit, the harmful associations must be gradually disconnected by an attempt at redirecting the will of the afflicted person. This is the best way to fight those inclinations that are directed towards forbidden pleasure. At the same time the inhibiting influence of despondency must be resolutely attacked. Victory over a habit formation will depend on the roots of this habit formation. Habits that are merely acquired may be broken more easily than those rooted in dispositional and hereditary traits...." (William Demal, O.S.B., D.D., *Pastoral Psychology In Practice*, New York, 1955, pp. 12-13).

25. Carnes, *Contrary To Love*, p. 23.

26. *Ibid.*

27. "...we have discovered that these are not just psychological diseases, they are also spiritual and affect every aspect of one's being. To recover does, indeed, require an entire systems shift. The 'Big Book' of Sex and Love Addicts Anonymous says it very well: 'Yet, whether we were aware of it or not, an entire being had been molded by our failure, or refusal, to solve from within the problems of our real lives: insecurity, loneliness, and lack of any abiding sense of personal worth and dignity. Through sex, charm, emotional appeal, or persuasive intellect, we had used other people as 'drugs' to avoid facing our own personal inadequacy. Once we saw this, we realized that in surrendering our addictive behavior we would inevitably have to question the whole foundation of our self-image, our personal identity....' It further states: 'As we came to appreciate the magnitude and mind-altering nature of sex and love addiction, and the extent to which it had perverted our value system, we had to admit that we could not reshape our whole identity unaided....'" (Schaefer, *Escape From Intimacy*, p. 110).

28. Carnes, *Contrary To Love*, p. 23.

29. *Ibid.*, p. 24. "... each of us is shaped by our past; who you are today is a mix of what you came into the world with and all your subsequent experiences. In that mix your family of origin has probably played one of the most powerful roles, not only in who you are, but in how you live today. Families hand down across generations not only their genetic pool but also their blueprint for how to live in the world." (Stephanie Covington and Liana Beckett, *Leaving The Enchanted Forest*, San Francisco, 1988, p. 14) According to Sprenkle, "current addiction theory suggests the etiology of many addictive behaviors may be related to a common set of experiences in the family of origin of the addict. Specifically, there is often a form of family intimacy dysfunction such as child abuse or neglect. In response to this trauma, the young person develops feelings of shame. These feelings are in part due to a belief that he/she was the cause of the abuse (Coleman, 1986). Feelings of shame lead to low self-esteem and dysfunctional interpersonal functioning which intensify loneliness in the child. In order to alleviate this psychological pain, the child begins to search for a 'fix' or some agent that has analgesic qualities. This agent may be alcohol, drugs, certain foods, working patterns, gambling, or sexual behavior. While these agents provide temporary relief, the shame, low self-esteem, and loneliness return. Consequently, there is a need to return to the 'fix,' the behavior becomes repetitive, and a vicious cycle develops which leads to a greater need to engage in the behavior for its analgesic qualities (Coleman, 1986)." (Douglas H. Sprenkle, "Treating a Sex Addict Through Marital Sex Therapy," *Family Relations Journal of Applied Family and Child Studies*, Vol. 36 (1), Jan./87, p. 12)

30. Carnes, *Contrary To Love*, p. 24.

31. *Ibid.*, p. 26.

32. *Ibid.* Nakken agrees with this theory, going so far as to see the potential for addiction in everyone: "The foundation of the addictive personality is found in all persons. It's found in a normal desire to make it through life with the least amount of pain and the greatest amount of pleasure possible." (Nakken, *The Addictive Personality*, p. 26) The desire to seek pleasure or avoid pain is not bad in itself, according to Nakken; the problem lies with the inability to regulate and control such desires. "The true start of any addictive relationship is when the person repeatedly seeks the illusion of relief to avoid unpleasant feelings or situations. This is nurturing through avoidance - an unnatural way of taking care of one's emotional needs. At this point, addicts start to give up natural relationships and the relief they offer. They replace these relationships with the addictive relationships." (*Ibid.*, p. 23) This "illusion of relief," in Carne's view, emerges again and again when



the sexual addict moves from phase four back to phase one of the addiction cycle - the preoccupation phase.

33. Carnes, *Contrary To Love*, p. 24.

34. *Ibid.*, pp. 31-32.

35. *Ibid.*, p. 47.

36. *Ibid.*, pp. 47-51.

37. *Ibid.*, p. 52.

38. *Ibid.*, p. 53. Gerald May describes the attachment process which, he believes, occurs in three stages: learning; habit formation; and struggle. "... the learning stage is characterized by associating a specific behavior with a feeling of pleasure or relief from pain . . . My brain automatically associates these effects with the behavior. If the pleasurable effect is immediate and powerful, my brain will make a strong association between the behavior and its effect in this single experience, and already it will be pushing to repeat the behavior. If the feelings are weaker or less immediate, it may take many reenactments of the behavior for my brain to solidify the association and start to request repeat performances. Either way, each time the behavior occurs, the association is reinforced, making me more likely to repeat it. Thus, certain attachments can develop almost instantaneously, while others may take a long time. This form of learning is known as conditioning; it is the primary way we 'learn' to be addicted, and it can happen altogether unconsciously. . . . When the conditioned pattern becomes associated with other experiences in my life, I will become more active in repeating the behavior. Then a full-fledged habit develops. . . . . Doing the behavior for its effects seems much more intentional than the automatic repetitions of Stage One, but it can still happen completely outside of consciousness. In most cases, I will be totally unaware that I am using the behavior in this way until Stage Three, when something prevents me from performing the behavior, or when it starts to cause problems." (May, *Addiction and Grace*, pp. 57-59).

39. Carnes, *Contrary To Love*, p. 53. Interestingly enough, Golwyn and Sevlie have argued that there may be a connection between sexual addiction and social phobia. For example, they point to one recent study where almost all the participants "had symptoms associated with atypical depression," (Daniel H. Golwyn, M.D. and Carol P. Sevlie, R.N., M.S.N., "Paraphilias, Nonparaphilic Sexual Addictions, and Social Phobia," *Journal of Clinical Psychiatry*, Vol. 53 (9), Sept./92; p. 330) a disorder which, much like social phobia, is "characterized by rejection sensitivity." (*Ibid.*) Another study found that its participants "may have had a greater capacity to achieve sexual excitement in relation to fantasy objects than within intimate relationships." (*Ibid.*) Our authors argue that since "'fantasy objects' would be less likely to reject and therefore less threatening to patients with rejection sensitivity than would adults in an intimate relationship," (*Ibid.*) it makes sense to suggest that "in these patients it is social anxiety that is blocking the normal capacity for reciprocal sexual activity and this leads to abnormal sexual behavior as the only sexual outlet." (*Ibid.*)

40. Carnes, *Contrary To Love*, pp. 53-4.

41. *Ibid.*, p. 54.

42. *Ibid.*, p. 56.

43. *Ibid.*, p. 59.

44. *Ibid.*, p. 78.

45. According to Schwartz and Brasted: "All addictions are chronic disorders that require rehabilitation rather than cure. Treatment is difficult and the prognosis variable." (Schwartz and Brasted, "Sexual Addiction," p. 106)

46. Carnes, *Contrary To Love*, p. 189.

47. *Ibid.*, p. 190. One of the reasons for this, says May, is that "the brain never completely forgets its old attachments, so the absence of conscious desire does not necessarily mean attachment is gone. In fact, because of the tricks our minds play on us, many of our addictions are able to exist for years completely outside our awareness; it is only when our addictions are frustrated or cause us conflict that we have an opportunity to notice how attached we truly are." (May, *Addiction and Grace*, p. 25) And again: "... Because of the deep and pervasive physical power of strong attachments, their potential exists forever in us, even after we have effectively broken the habit of acting upon them . . . It stands ready to come back to us with only the slightest encouragement . . . Years after a major addiction has been conquered, the smallest association, the tiniest taste, can fire

up old cellular patterns once again. . . From the standpoint of psychology, this means we can never become so well adjusted that we can stop being vigilant. From a neurological viewpoint, it means the cells of our best-intentioned systems can never eradicate the countless other systems that have been addicted. And from a spiritual perspective, it means that no matter how much grace God has blessed us with, we forever remain dependent upon its continuing flow." (Ibid., pp. 89-90)

48. Carnes, *Contrary To Love*, p. 190.

49. Ibid., pp. 190-191.

50. Ibid., p. 191.

51. Ibid.

52. Ibid., p. 199. According to Schwartz and Brasted ("Sexual Addiction," p. 106), "Many sexual addicts are ex-alcoholic or drug abusers and simply present with a new or dual addiction." Sprenkle claims there are many sex addicts who use alcohol as "a means of anesthetizing pain related to their sexual behavior." (Sprenkle, "Treating a Sex Addict Through Marital Sex Therapy," pp. 11-12) Kafka's work suggests that "some paraphilias and nonparaphilic sexual addictions, found in association with a mood disorder, can be effectively treated with antidepressant medications" such as "fluoxetine, imipramine, or lithium." (Kafka, "Successful Antidepressant Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men," p. 60) cf. Kafka and Prentky, "Fluoxetine Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men," pp. 351-358; see also Stein, Hollander, Anthony, Schneier, Fallon, Liebowitz, and Klein, "Serotonergic Medications for Sexual Obsessions, Sexual Addictions, and Paraphilias," pp. 267-271, who argue that paraphilic and nonparaphilic sexual addictions, as well as sexual obsessions each respond in varied ways to medication.

53. "Because of multisystem involvement, breaking an addiction usually requires changes in many different areas of life. A person trying to stop smoking will find the struggle much greater after eating . . . or at other times that have become associated with cigarettes . . . Multisystem involvement is also responsible for temporary experiences of freedom when a person's environment changes. A compulsive overeater, for example, will struggle in agony with his addiction to food while in his usual environment. But if he goes on a backpacking trip in the mountains, he may feel quite free of the addiction. In the new environment, he is sufficiently removed from other stimuli that have become associated with his addiction, and he can much more easily deal with his primary urge to eat. He may even think he has finally overcome the problem, only to be deeply disappointed when he returns to his usual surroundings and finds all of his associations triggered afresh . . ." (May, *Addiction and Grace*, pp. 85-86)

54. Carnes, *Contrary To Love*, p. 227.

55. Ibid., p. 228. "The first component of successful treatment is stopping the undesirable sexual activity. Aversive behavioral techniques of covert sensitization and fantasy satiation are used to temporarily stop the sexual acting-out. Occasionally, antiandrogen or tranquilizers can provide adjunctive, temporary amelioration." (Schwartz and Brasted, "Sexual Addiction," pp. 106-107)

56. Carnes, *Contrary To Love*, p. 234. "The first prerequisite for intimacy is to be intimate with oneself . . . In order to be intimate with another person, we have to know who we are, what we feel, what we think, what our values are, what is important to us, and what we want. If we do not know these things about ourselves, we can never share them with another person. Addicts cannot be intimate, because they have used their addictions to turn off their internal information systems and therefore cannot have available to themselves information about what they feel and think and who they really are. . . They must notice when they like something or do not like something. They must be able to notice when they are hurt, angry, afraid, lonely, needy, happy, or at ease . . ." (Schaeff, *Escape From Intimacy*, pp. 123-124)

57. While admitting that the effectiveness of treatment for sexual addiction is still largely an unknown, Schwartz, like Carnes, views the assessing and modifying of the addict's thinking and belief system as essential for the treatment of sexual compulsivity. Such faulty cognitions and beliefs lead to interference with his/her ability to relate sexuality with intimacy. Arming the addict with this knowledge may help remove some of the shame involved, and thus, open the door to the possibility of behavioral change. (Mark F. Schwartz, "Sexual Compulsivity as post-traumatic stress disorder: Treatment Perspectives," *Psychiatric Annals*, Vol. 22 (6), June/92, pp. 333-338.

58. Carnes, *Contrary To Love*, pp. 236-237. "An example of a common feature of the sexual addict who comes to a clinic is denial and rationalization. Patients may minimize the severity of



their problem by claiming that they did not hurt anyone, by rationalizing that their partner once had an affair with another man, or by otherwise justifying their sexual deviance. To counteract such assertions, the addict is shown that he can be responsible for his own actions and does not have to blame other people or events. The therapist confronts such irrational beliefs, statements reflecting poor self-image, unrealistic expectations, anticipated failure, and easily elicited defensiveness, all of which are destructive to self-esteem, and replaces them with positive ways of thinking." (Schwartz and Brasted, "Sexual Addiction," p. 107)

59. Carnes, *Contrary To Love*, p. 238.

60. Ibid.

61. Ibid., p. 245.

62. Ibid., p. 246. It is May's understanding that this powerlessness is the direct result of the binding power of attachment: "The word attachment has long been used by spiritual traditions to describe this process. It comes from the old French *attache*, meaning 'nailed to.' Attachment 'nails' our desire to specific objects and creates addiction. In this light, we can see why traditional psychotherapy, which is based on the release of repression, has proven ineffective with addictions. It also shows why addiction is the most powerful psychic enemy of humanity's desire for God." (May, *Addiction and Grace*, p. 3) "... The usual psychiatric and psychological techniques have not been very effective with these behaviors. Yet when we treat them as addictions, improvement occurs ..." (Schaefer, *Escape From Intimacy*, p. 143.)

63. Carnes, *Contrary To Love*, p. 246.

64. Ibid., p. 247.

65. Ibid., p. 250.

66. Carnes, *Contrary To Love*, p. 252. "The couple is ready to leave therapy when the presenting problem has been solved, the legitimate relationship and sexual needs of the parties are being met, and the couple has the interpersonal skills to handle future relationship and sexual problems ..." (Sprenkle, "Treating a Sex Addict Through Marital Sex Therapy," p. 13)

67. Carnes, *Contrary To Love*, p. 252. "The sexual addict agrees to a contract specifying that he will stop acting-out for at least six months to allow therapy to take effect." (Schwartz and Brasted, "Sexual Addiction," p. 107)

68. Carnes, *Contrary To Love*, p. 252. "During this time the need for clear touching and physical contact may be important. It will be up to each person to know what threatens her or his sobriety; hugs, squeezes ... may be very important ..." (Schaefer, *Escape From Intimacy*, p. 156)

69. Carnes, *Contrary To Love*, pp. 252-3.

70. "As the sedating effect of the addictions is removed, many feelings and memories that have been held down by the addiction will emerge. It is important to pay attention to these and find safe places to work them through. We can share these feelings in twelve-step groups ..." (Schaefer, *Escape From Intimacy*, p. 157)

71. This spiritual comes as a result of a shift in priorities. In the height of their addiction, their "fixation on the immediacy of sex forces them to always find new bodies. But they are unconsciously searching for transcendent love in their exploits." (Thomas J. Tyrrell, *Urgent Longings*, Whitinsville, MA, 1980, p. 60.) Compare with Robert Johnson (*WE: Understanding the Psychology of Romantic Love*, New York, 1983, p. 152), who writes: "... We walk through life longing for a transfiguring experience, the vision that will give our lives meaning and wholeness: We are searching for our souls, searching for the divine world ... Unconsciously, impulsively, like men and women possessed, we seek it in passion, falling in love, delivering ourselves over to a power that envelops us and possesses us. It is ecstasy, it is suffering, it is a kind of death, but most of all it is a taste of what used to be sought in the afterlife: transfiguration ..."

72. Carnes, *Contrary To Love*, p. 255.

73. Ibid. This point is important, for as Schaefer notes, "sexual addiction is a way of actively avoiding nurturance and intimacy. Sexual addicts use relationships to get their fix. They are not really interested in love, romance, or relationships; however, frequently, if they pretend they are, they stand a better chance of getting their sexual 'fix' under culturally approved circumstances ..." (Schaefer, *Escape From Intimacy*, pp. 33-34)

74. "Weekly psychotherapy is mostly cognitive-behavioral and directed toward reversing the patient's helplessness. At each session, addicts are given individualized behavioral suggestions

geared to making them feel more powerful and effectual. Negative emotions are identified as signals for problem solving or assertive action." (Schwartz and Brasted, "Sexual Addiction," p. 107)

75. Carnes, *Contrary To Love*, p. 262. In order to counter such stressors, "alternative means of coping with these feelings, including relaxation, socializing, exercise, problem solving, self-assertiveness, and self-disclosure with a lover, are taught and encouraged in weekly sessions . . ." (Schwartz and Brasted, "Sexual Addiction," p. 107)

76. Carnes, *Contrary To Love*, p. 263.

77. *Ibid.*, p. 264. "The therapist tries to replace the thrill of self-destructive behavior with the rewards of genuine intimacy. Successful treatment requires helping the individual to establish a healthy, committed primary relationship and a network of secondary relationships. Treatment is not complete until this is achieved; the patient is at risk of relapse until he can experience a state of intimacy with another adult . . ." (Schwartz and Brasted, "Sexual Addiction," p. 107.)

78. Adrian van Kaam, C.S.Sp., *Religion and Personality*, Garden City, N.Y., 1968, pp. 122-123.

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